Child Abuse and Neglect Annual Report of Fatalities and Near Fatalities

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Department for Community Based Services
Cabinet for Health and Family Services

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Contents

Introduction

In accordance with KRS 620.050(12), the Cabinet for Health and Family Services (cabinet or CHFS), Department for Community Based Services (department or DCBS) submits this annual report of child abuse and neglect fatalities and near fatalities. The report is designed to provide insight into the circumstances that resulted in deaths or near deaths of children who had a protection service history with the Department. The report is organized into four sections: Trends in Child Fatality and Near Fatality Cases; Predicting Child Fatalities and Near Fatalities; Child Fatalities and Near Fatalities in State Fiscal Year (SFY) 2014; and State Program Improvement Efforts. Historical data in this report span the previous five state fiscal years and include only child abuse and neglect fatalities and near fatalities with prior agency involvement.

Historical trend data presented in Table 1 has been updated from the annual report of child abuse and neglect fatalities and near fatalities submitted for SFY 2013. An asterisk indicates that the number has been updated from the prior year's report. The number of child fatalities and near fatalities are subject to change as pending cases are resolved and as coroners complete death investigations and make new reports applicable to a prior fiscal year. Alternately, cases that were initially reported as a near fatality but ultimately ended in death have been updated to reflect the fatality. Additionally, numbers may decrease when an administrative or court hearing overturns an agency determination from substantiated to unsubstantiated. Near fatalities and fatalities that occurred in SFY 2014 are reported as they are reflected in the database at the time of the report. Changes in the 2014 column will be updated in subsequent reports.

Section I: Trends in Child Fatality and Near Fatality cases

In order to establish a context under which child death and serious injury occurs, general child maltreatment data are included in this report. Table 1 provides data on the overall number of calls with allegations received by the Department, the total number of child abuse/neglect reports that met criteria, the number of those cases in which abuse or neglect was found, and the number of fatality and near fatality cases that were the result of maltreatment. In January 2014, the department began migrating to a new data system. With the launch of iTWIST, the types of calls received by DCBS are more specifically categorized. The department now captures all requests for assistance as well as all reports of abuse or neglect. Requests for assistance includes such things as court ordered home evaluations, interstate requests for

assistance, and placement monitoring reports. This enhanced method of capturing calls is reflected in the total number of calls for SFY 14, accounting for the appearance of an increase in call numbers from prior years. While the department typically *does* see an increase in the number of reports from year to year, the significant jump in "calls received" in 2014 is inclusive of the improved ability of the department to document all of the child welfare related calls and activities, in addition to handling reports of abuse and neglect.

Table 1: SFY 2010-2014 Fatalities and Near Fatalities that Resulted from Abuse or Neglect, Updated to Reflect the Resolution of Pending Reports or Changes in Findings

	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14
Number of calls received	77,635	79,943	87,447	95,334	145,576
Number of abuse/neglect reports that met criteria	47,950	47,825	50,953	58,125	64,393
Number of children involved in reports that met criteria	66,285	66,389	70,385	80,231	89,193
Number of abuse/neglect reports that were substantiated	9,477	9,595	9,935	11,288	12,120
Number of children involved in cases in which abuse/neglect were substantiated	15,092	15,510	15,699	17,884	19,407
Number of *fatalities* in which abuse/neglect was substantiated	35	31	32	22*	12
Number of substantiated abuse/neglect fatalities with DPP history	23	18*	11	17*	9
Number of *near fatalities* in which abuse/neglect was substantiated	51	48	44	46*	29
Number of substantiated abuse/neglect near fatalities with DPP history	26	25	28	32*	19
Note: Increase between SFYs 13 and 14 is partially due to launch of iTWIST. An asterisk (*) indicates adjustment from prior year's report due to fatality/near fatality review process.					

The small number of child maltreatment cases that result in serious injury or death each year creates significant trend fluctuations and does not provide a representative picture of these cases. For this report, the department incudes data on all substantiated fatality and near fatality cases (SFY 2010-2014) that have prior protection and permanency history in order to strengthen the capacity to describe case trends. In the past five years (SFY 2010-2014), there have been 350 fatalities and near fatalities due to abuse or neglect. Of those cases, 208 (59%) had prior involvement with the department. This report focuses on the 208 children involved in a substantiated child abuse or neglect event that resulted in their death or serious injury and the circumstances which surrounded that event.

Gender, Race and Ethnicity of Child Victims

According to the 2012 Administration for Children and Families (ACF) child maltreatment report[1], nationally, 58% of child fatality maltreatment victims were male and 42% were female. Gender distribution among the 208 children in this report closely resembled those data with 59% of Kentucky victims being male and 41% female. Kentucky census data from 2010 indicates males account for 49.2% of the population and females account for 50.7%.

Table 2- Percentage of KY child victims by gender for SFY 2010-2014 (N=208)

	Gender of the Victim	
	KY (N=208)	National Fatality Data (ACF 2012 NCANDS Report N=54,735,278)
Male	59%	58%
Female	41%	42%

Caucasian children account for 78% of the 208 child fatalities and near fatalities from SFY 2010-2014. African American children account for 14%, and 5% of victims were identified with two or more races. Table 3 displays the racial and ethnic characteristics of the child victims in Kentucky between SFY 2010 and 2014. Nationally, however, the racial and ethnical distributions of child victims are more diverse.

Table 3- Percentage of KY child victims by race/ethnicity for SFY 2010-2014

Race or Ethnicity	Kentucky Fatality/Near Fatality Data (N=208)	2010 Detailed Census Data for Kentucky (N=4,339,367)	National Fatality Data (ACF 2012 NCANDS N=54,735,278)
African American	14%	8%	31.9%
Two or More Races	5%	2%	3.8%
Caucasian	78%	88%	38.3%
Hispanic	2%	3%	15.3%
Pacific Islander	0%	5%	.3%
American Indian or Alaskan Native	0%	1%	.9%
Asian	0%	1%	.9%
Unknown	0%	N/A	8.6%

[1] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012.* Available from http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2012

Perpetrator Demographics

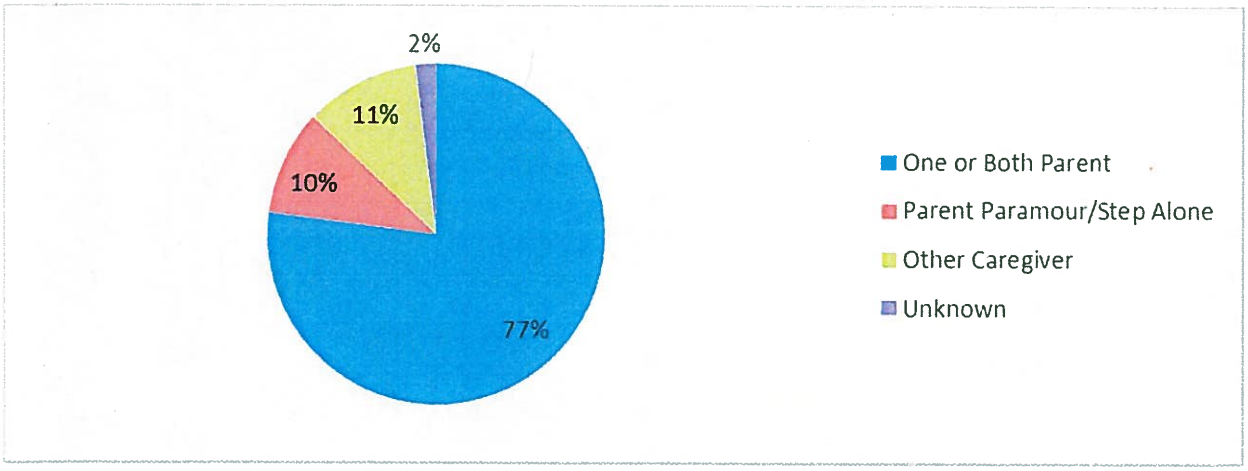
In the 208 cases referenced in this report, there were 345 identified perpetrators. Seventy percent of the female perpetrators were between the ages of 20 and 30, while 57% of male perpetrators fell into this age range. Female perpetrators of abuse and neglect tended to be younger. Male perpetrators, while also tending to be younger, were more evenly distributed along the scale of chronological age.

Table 4- Percentage of KY caretaker by age and gender for SFY 2010-2014

Age of Male and Female Caregivers at Incident		
	Male (n=157)	Female (n=188)
20 and Under	4%	14%
21-25	29%	35%
26-30	26%	28%
31-35	24%	10%
36 and Over	17%	13%

Data consistently indicate that parents, acting alone or in collusion with another, are most frequently the perpetrators of fatal and near fatal abuse or neglect. From SFY 2010 through 2014, 77% of fatalities and near fatalities involved a parent as a perpetrator. This trend is replicated nationally. The federal Administration for Children and Families' most recent report on child maltreatment found parents as perpetrators in 80% of child abuse and neglect cases.[2]

Table 5- Percentage of KY caretaker relationship to victim for SFY 2010-2014 (N=208)

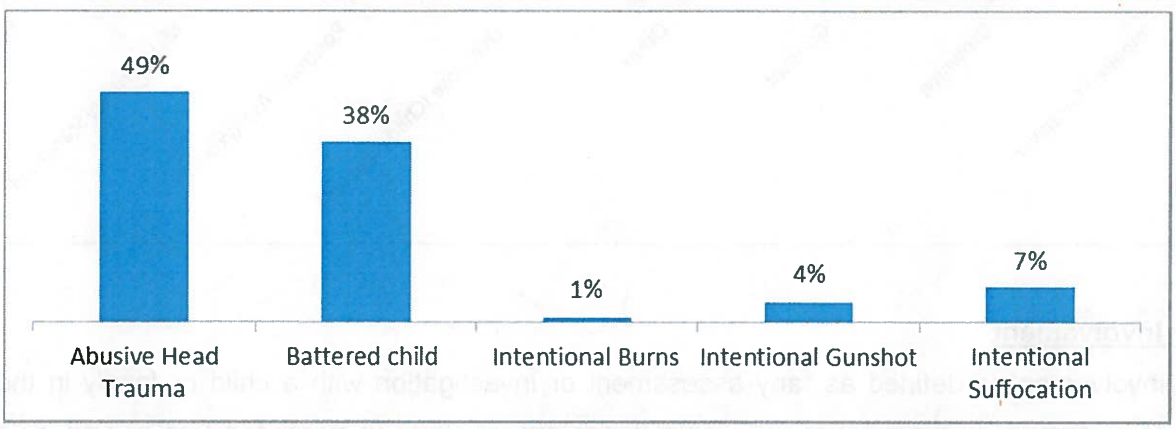


[2] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012.* Available from http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf

Maltreatment Type

In this analysis, child maltreatment is broken into two categories: physical abuse and neglect. Of the 208 cases, 94 cases were the result of physical abuse, and 115 resulted from neglect (total of 209 findings).[3] Table 6 displays causes of death or serious injury in the 94 physical abuse findings for SFY 2010 to 2014.

Table 6- Percentage of KY child victims- physical abuse for SFY 2010-2014 (N=94)

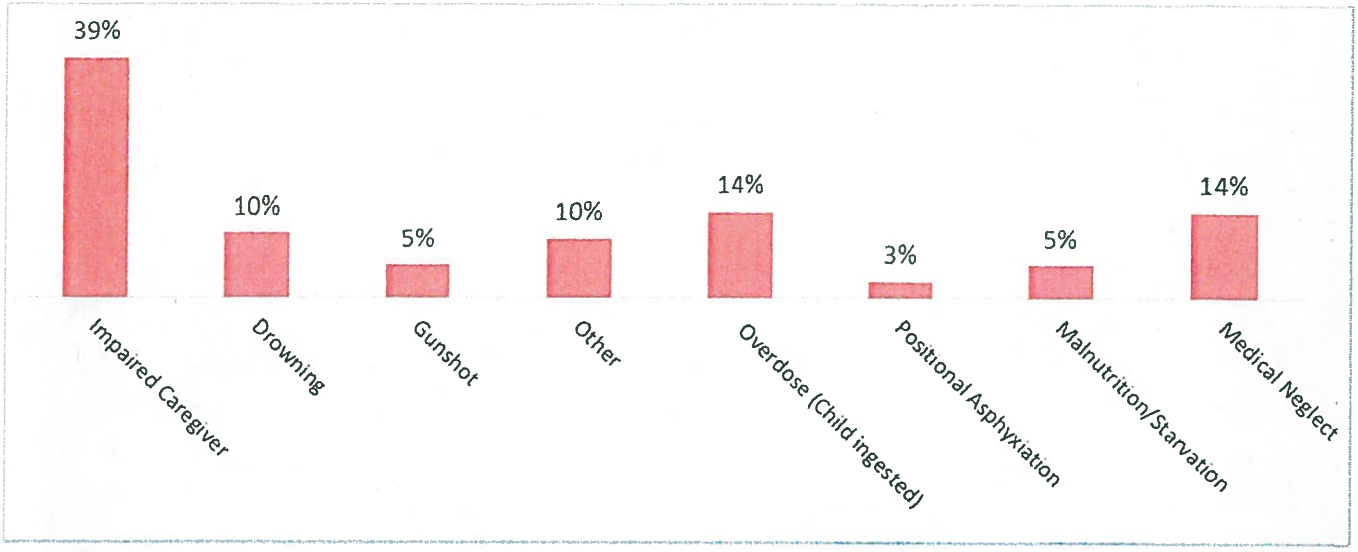


Of the 94 physical abuse findings, the leading cause of death or serious injury continues to be abusive head trauma, accounting for 49% of injuries. Battered children, those with multiple injuries, account for 38% of physical abuse deaths or serious injuries.

For SFY 2010 to 2014, 115 of the 208 total fatalities and near fatalities were the result of neglect. Table 7 depicts the causes of death or near death. These neglect cases fell into four broad categories: lack of supervision of the child, impaired caregivers, malnutrition or starvation, and caregivers not meeting the medical needs of the child. Impaired caregivers include any incident of death or near death for which the caregiver's substance use contributed to the incident. The two most frequently identified causes of death or near death in which neglect was found involved caregivers who did not provide appropriate supervision (42%) and caregivers whose impairment led to the fatal or near fatal event (39%).

[3] One case included both physical abuse and neglect findings as the cause of serious injury could not be determined.

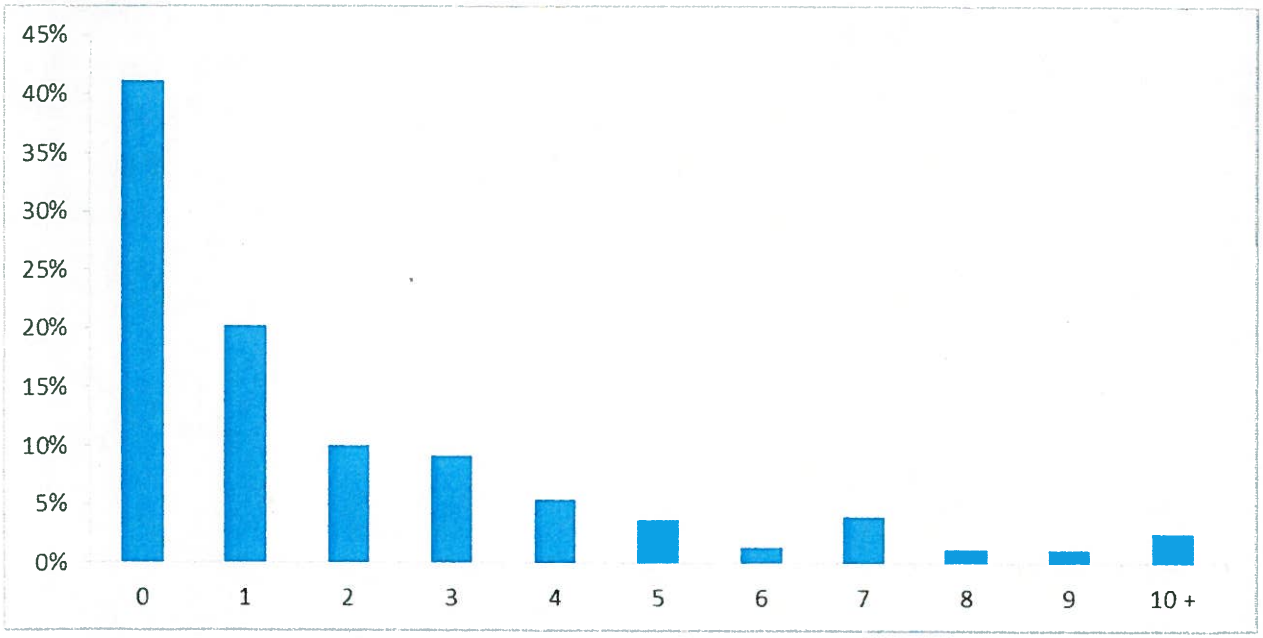
Table 7- Percentage of KY child victims- neglect for SFY 2010-2014 (N=115)



Prior Involvement

Prior involvement is defined as "any assessment or investigation with a child or family in the area of protection and permanency." Table 8 displays all 350 substantiated fatality and near fatality events occurring from SFY 2010-2014. As previously stated, 41% of those 350 incidents, did not have prior involvement with DCBS protection and permanency services.

Table 8- Number of prior investigations or assessments with DCBS protection and permanency in cases of child abuse and neglect related fatalities and near fatalities SFY 2010-2014 (N=350)

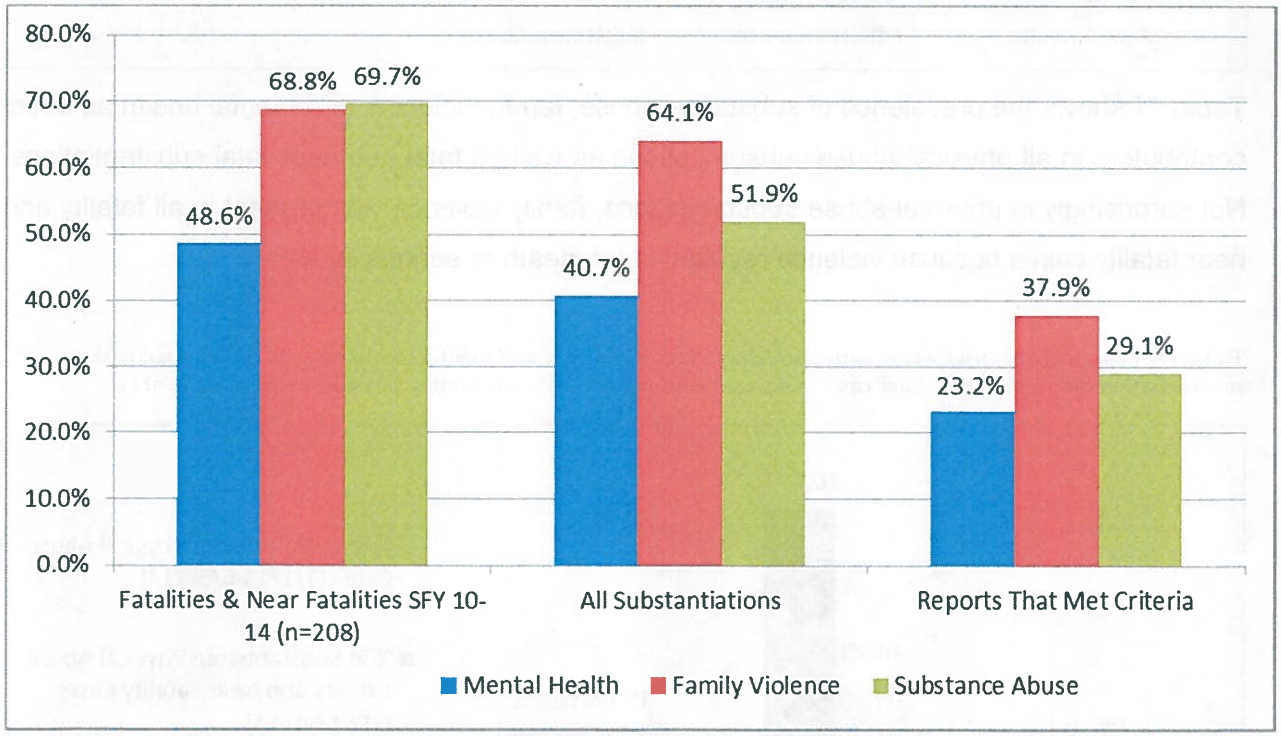


Household Dynamics

Substance abuse, domestic violence, and mental health issues are commonly known antecedents in child abuse and neglect cases. In previous years, the department has reported rates of these issues when they were present in the case as a risk factor regardless if the issue directly contributed to serious or fatal injury.

Table 9 describes the percentage of cases where substance abuse, domestic violence, and mental health issues were present in the case for fatality and near fatality cases (SFY 10-14) , substantiated cases, as well as for all cases with abuse/neglect allegations. These data are consistent with what has been reported in prior years. Family violence is the most common risk factor present across all reports. In fatality and near fatality cases, however, substance abuse and family violence are present with near equal frequency.

Table 9- Percentage of cases showing evidence of three risk factors: substance abuse, domestic violence and mental health; for cases involving fatalities or near fatalities (F/NF), all substantiated cases and all child protective services cases



The department now has the ability to distinguish if a risk factor is present in the home, indirectly contributed to the incident, or directly contributed to the incident. Moving forward, this will allow for a richer understanding of how household dynamics impact child maltreatment moving forward. Data were manually extracted for child fatality or near fatality cases and therefore available for all 28 cases for SFY 14; however, data for all cases were only available beginning in January 2014.

Table 10 portrays neglect substantiations for all cases compared to neglect substantiations in fatality and near fatality cases. Substance abuse directly contributed to approximately half of all neglect substantiations and just over 47% of the fatality and near fatality neglect substantiations.

Table 10- Percentage of cases where substance abuse, family violence and mental health directly contributed to the substantiation for all neglect cases compared with fatality and near fatality neglect cases (n=17).

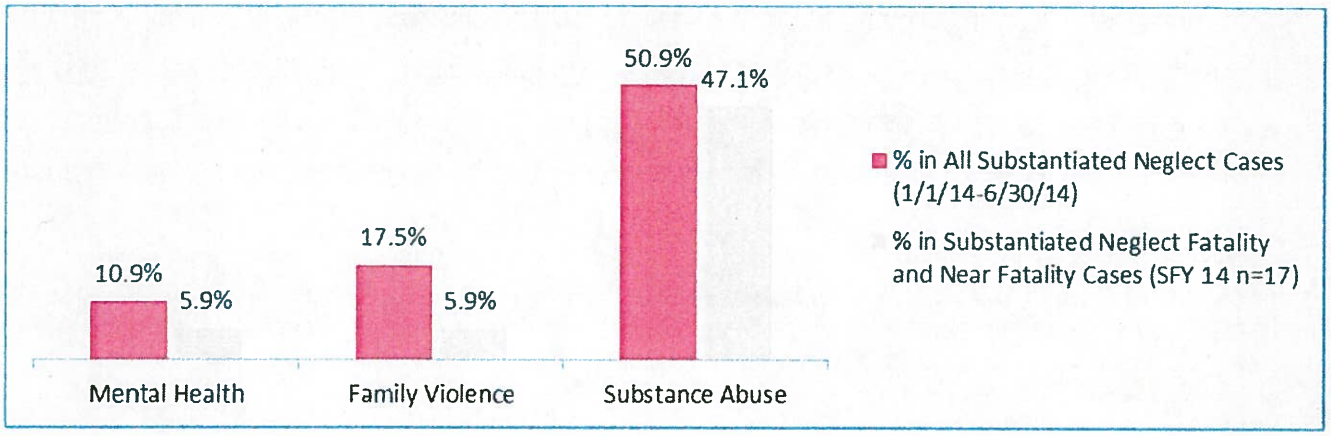
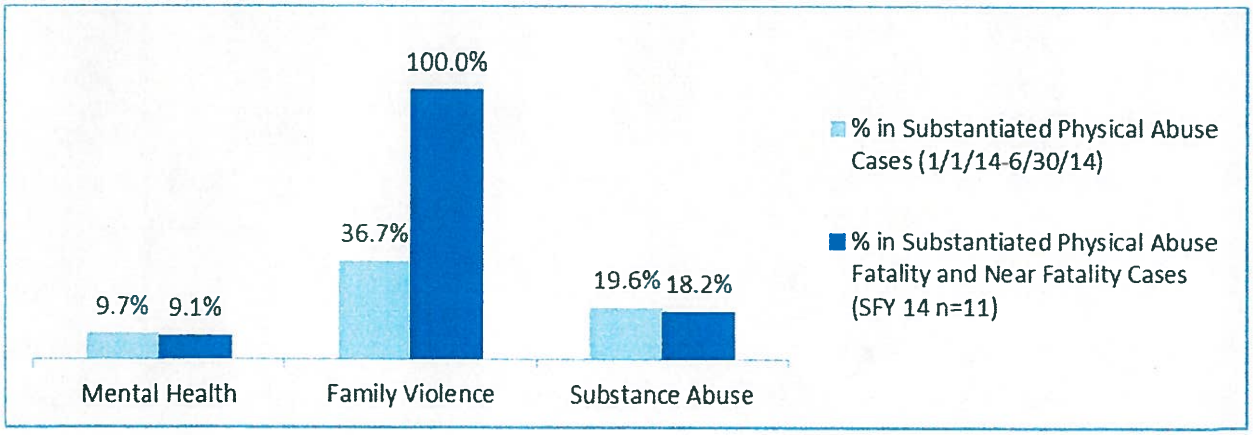


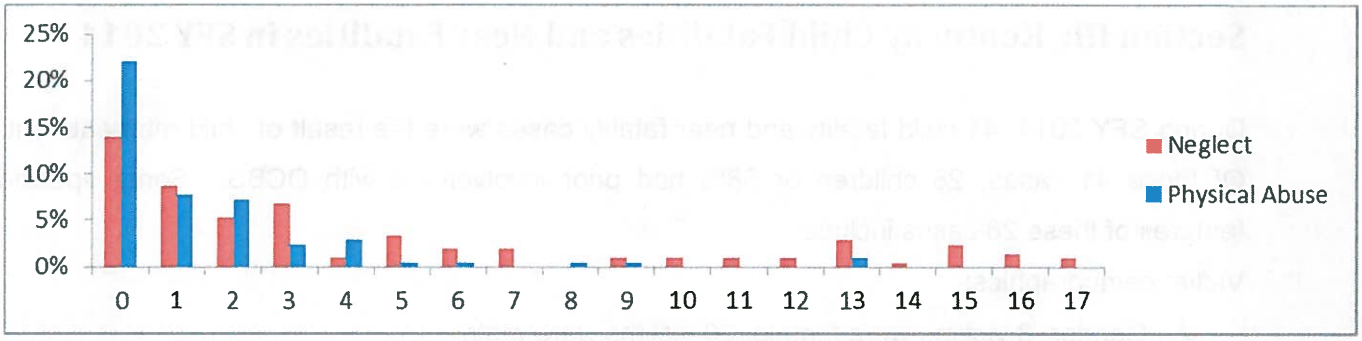
Table 11 shows the prevalence of substance abuse, family violence, and mental health as direct contributors in all physical abuse substantiations as well as fatal and near fatal substantiations. Not surprisingly in physical abuse substantiations, family violence was present in all fatality and near fatality cases because violence resulted in the death or serious injuries.

Table 11- Percentage of cases where substance abuse, family violence and mental health directly contributed to the substantiation for all physical abuse cases compared with fatality and near fatality physical abuse cases (n=11).



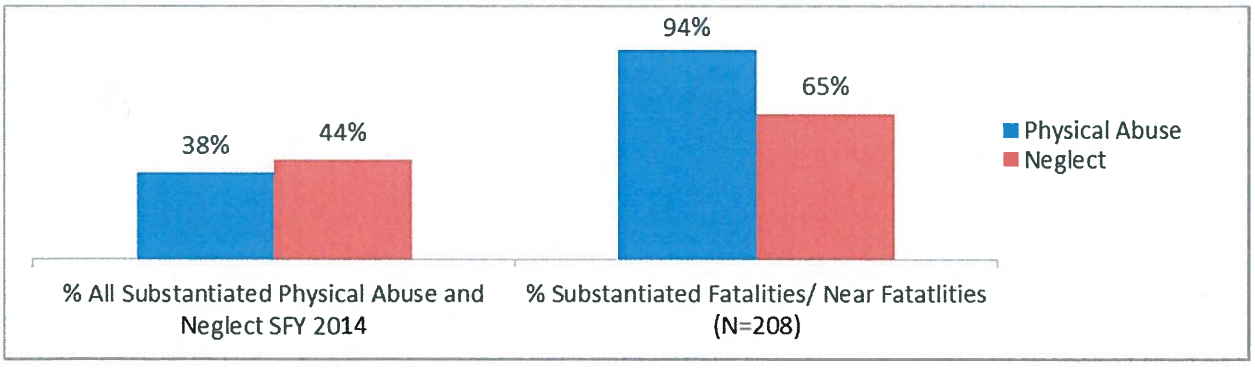
The age of the victim has been the one child demographic that has been consistently useful as a predictive feature for caseworkers and policy makers in cases of fatal and serious child maltreatment. Table 12 displays the percentage of victims by age in the 208 cases for this year's annual report.

Table 12- Percentage of Kentucky children by age for SFY 2010-2014 (N=208)



For SFY 2014 in Kentucky, 94% of all cases of fatal or near fatal physical abuse involved children four years of age and younger. The age of children in neglect-related fatalities or near fatalities is more equally distributed across age groups, although the majority of victims still tend to be aged four years or younger. These data show an important relationship between the age of the victim and the type of maltreatment; physical abuse is lethal to small children. As a result of these findings, allegations related to children age four and younger are evaluated as more urgent in both the initiation and investigative protocol in the Commonwealth. Table 13 represents the percent of youth aged four and under by maltreatment type in all physical abuse and neglect substantiations compared to fatality and near fatality substantiations.

Table 13- Percentage of children 4 and under with substantiated abuse and neglect (all cases) versus percentage of fatality and near fatality victims 4 and under



The department continues to evaluate the constellation of case features present in child abuse and neglect cases that result in fatal or near fatal outcomes. Families involved in the child

welfare system present with a myriad of trauma histories and risk factors, including mental health issues, substance abuse histories, unstable living conditions, and a variety of other household dynamics, such as access to resources and household structures. Understanding the impact of these features remains a work in progress.[4] DCBS continues to work with medical, legal, and other community partners to increase our understanding of what situations result in fatal and near fatal child abuse.

Section III: Kentucky Child Fatalities and Near Fatalities in SFY 2014

During SFY 2014, 41 child fatality and near fatality cases were the result of child maltreatment. Of those 41 cases, 28 children or 68% had prior involvement with DCBS. Some specific features of these 28 cases include:

Victim demographics:

- Gender- 8 victims were female, 20 victims were male.
- Age- 18 victims were four years of age or younger, 8 of those were under one year of age.

Case demographics:

- Perpetrator- One or both parents accounted for 21 of the 28 perpetrators.
- Maltreatment- In 11 of the 28 cases physical abuse resulted in the death or near death.
- Substance Abuse- In 10 of the 28 cases substance abuse directly contributed to the death or near death of the child. Most commonly, the use of opiates and other prescription drugs was found to be present in the home.
- Family violence- In 12 of the 28 cases violence in the home directly resulted in the death or serious injury of the child victim.

[4] Reference : "Predicting child fatalities among less-severe CPS investigations." J. Christopher Graham, Kelly Stepura, Donald J. Baumann , Homer Kern. Children and Youth Services Review. 2010: 32 (274–280)

Regional Differences

The chart that below shows the distribution of child fatality cases and near fatality cases in each of the nine DCBS service regions during SFY 2014. See Appendix A for a regional map of counties in each service region.

Service Region	# of abuse/neglect fatalities with prior involvement	# of abuse/neglect near fatalities with prior involvement	Total fatality/ near fatality with prior involvement
Cumberland	2	6	8
Eastern Mountain	0	0	0
Jefferson	1	2	3
Northeastern	2	4	6
Northern Bluegrass	2	1	3
Salt River Trail	1	0	1
Southern Bluegrass	0	1	1
The Lakes	0	3	3
Two Rivers	1	2	3
Statewide Totals	**9**	**19**	**28**

Section IV. Kentucky's Program Improvement Efforts

The department engages in a variety of quality assurance activities aimed at driving program improvements. DCBS utilizes a comprehensive and standardized case review tool and a random standardized case analysis process for quality assurance purposes. The department uses data collected during case reviews to inform decision making in the areas of policy, practice, and training.

Internal Reviews

The department continues to conduct internal reviews, as mandated by KRS 620.050(12), and has implemented additional reviews for all fatality and near fatality cases if there is previous history, regardless of whether the death or near death was the result of substantiated abuse or neglect or not. Prior involvement is defined by 922 KAR 1:420 as "any assessment or investigation, of which the cabinet has record, with a child or family in the area of protection and

permanency prior to the child's fatality or near fatality investigation." The purpose of the internal review is to review the agency's prior intervention and identify areas for improvement.

There were 28 cases that required an internal review during SFY 2014. In order to better understand the opportunities for improvement, issues were organized into nine basic areas:

Lack of documentation- defined as "work was completed correctly, but not captured in the documentation";

Lack of Knowledge of Standards of Practice (SOP)- defined as a "lack of understanding basic SOP guidelines related to a specific aspect of work";

Risk Assessment- defined as "inability to identify protective factors, risk factors, and/or safety factors";

Community Relations- defined as "difficulty in partnering and/or communicating across agencies";

Interagency Service Delivery- defined as "services were identified and needed, but not available in the service area of the family";

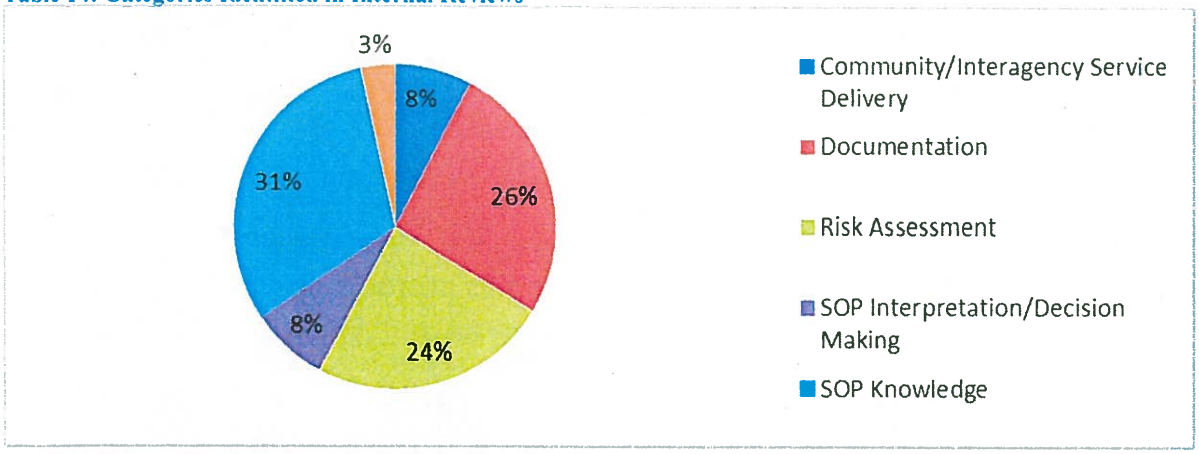
SOP interpretation/decision making- defined as "inability to apply and integrate information gathered in a risk assessment";

Training- defined as "an identified need or request for information not related to specific policy";

Technology- includes issues with The Worker Information System (TWIST), the network, and other technology.

The majority of issues identified during the internal review process revolved around SOP knowledge (31%), documentation (26%), or risk assessment (24%). Table 14 displays the distribution of all issues identified in the 28 internal reviews.

Table 14: Categories Identified in Internal Reviews



. **Initiatives and Programmatic Improvements**

The department has also undertaken various initiatives and program improvements as a result of internal review and case reviews.

- As a culmination of child death review and the lethality research conducted by DCBS, a new investigative assessment tool was implemented to guide case decision-making. The new tool features guide staff through the areas of assessment and prompts for both risk factors and protective factors. The tool is available for field staff to take with them while they complete the investigation or assessment and includes a safety component in addition to a risk of future maltreatment section. This new assessment tool, the Assessment and Documentation Tool (ADT), was implemented in January 2014 and an evaluation of its impact is currently beginning.

- An assessment of centralized intake acceptance criteria has been underway in the department to inform policy making. These efforts have been informed by the policy reviews and internal reviews conducted in DCBS. A workgroup has been formed to review and revise existing policy to provide more triage of high risk reports.

- DCBS enhanced the internal review process for child abuse/neglect fatalities and near fatalities. The expanded process includes action planning to address both systemic and local issues, as well as accountability for staff through central office and regional follow-up on action plans. A policy review component is included in each review regardless of finding or case disposition. A second full time policy analyst was added to the division to ensure the child fatality program has the capacity to provide statewide training and technical assistance as well as internal review of cases.

- The Division of Forensic Medicine (DFM) in the Department of Pediatrics at the University of Louisville has provided forensic consultations and medical evaluations of child victims of abuse and neglect. The collaboration between DFM and DCBS assists staff who are completing and documenting child protective services investigations. The Division of Forensic Medicine also provides court testimony, when warranted, and assist the Child Fatality Nurse Service Administrator on cases of physical abuse and neglect as needed. This collaboration assists DCBS in differentiating inflicted injury from accidental trauma. Approximately 600 referrals from DCBS staff for consultations have occurred over the past state fiscal year.

- DCBS worked collaboratively with the External Child Fatality and Near Fatality Review Panel throughout the Fiscal Year in order to provide all child fatality and near fatality cases in an organized manner. The External Panel was updated monthly with new cases received for SFY 2014. Any additional information from outside sources the Panel members requested, DCBS attempted to gather to assist with the reviews.

- As a result of risk assessment issues identified during internal reviews, several service regions have requested additional training around identification of risk factors during investigations. This training was held for staff of the region in April 2014 and additional sessions of this training have already been scheduled to occur next fiscal year in that region as well as others.

Trainings

The department utilizes information gained during internal reviews to implement trainings to enhance knowledge and skills of staff. DCBS also conducts additional case reviews in order to understand the complex factors present in the families and children served by the agency.

- "Assessment Training" While the department was rolling out the new assessment tool, a specific trainings were conducted across the state focusing on risk and safety assessments. This training consisted of hands on training with actual cases to discuss decision making and provide additional technical assistance to staff. The training was done for all regional management staff, front line supervisors, and front line investigators.

- *"Risk Factors and the Assessment of Child Protective Service Investigations"* training emphasizes the assessment of domestic violence, mental health, and substance abuse in families, and strongly emphasizes the use of comprehensive interviews with service providers and family members to appropriately assess the strengths and needs of families. A team approach to training is used that includes both frontline staff and their supervisors. The goal of this training is to improve clinical decision making by staff and supervisors. This training has been provided in all nine DCBS service regions in past years and is offered ongoing as needs are identified.

- *"Medical Elements of Child Abuse and Neglect" (MECAN)* is a series of medical trainings designed for the non-medical professional to provide information on a variety of medical topics. This series was developed in 2007 by the DCBS Child Fatality Nurse Service Administrator and revised in 2011 with the assistance of Dr. Melissa Currie, Director of the Division of Pediatric Forensic Medicine at the University of Louisville. Twelve 2-3 hour courses are currently available on a variety of medical issues related to child maltreatment. Several trainings have been converted to modules on the KYTRAIN network, administered by the Department for Public Health, for access by both DCBS staff and community partners. The goal of the training is to increase recognition of medical indicators of abuse and neglect for staff, supervisors, and community partners. Individual modules are presented throughout the year in addition to their availability on the KYTRAIN network.

- *"Bruises and Patterned Injuries"* is the most often provided module of the MECAN series and is presented by the DCBS Child Fatality Nurse Service Administrator. This training provides information on types, locations, and variations of bruises and other skin injuries. It is provided to all DCBS Protection and Permanency staff at the beginning of their employment, ongoing as needed to DCBS supervisors and staff, and to community partners including the Community Collaborations for Children (CCC) Regional Networks. The purpose of the training is to provide information to these individuals to heighten awareness of abusive injuries. Several sessions of this training were held around the Commonwealth during SFY 2014.

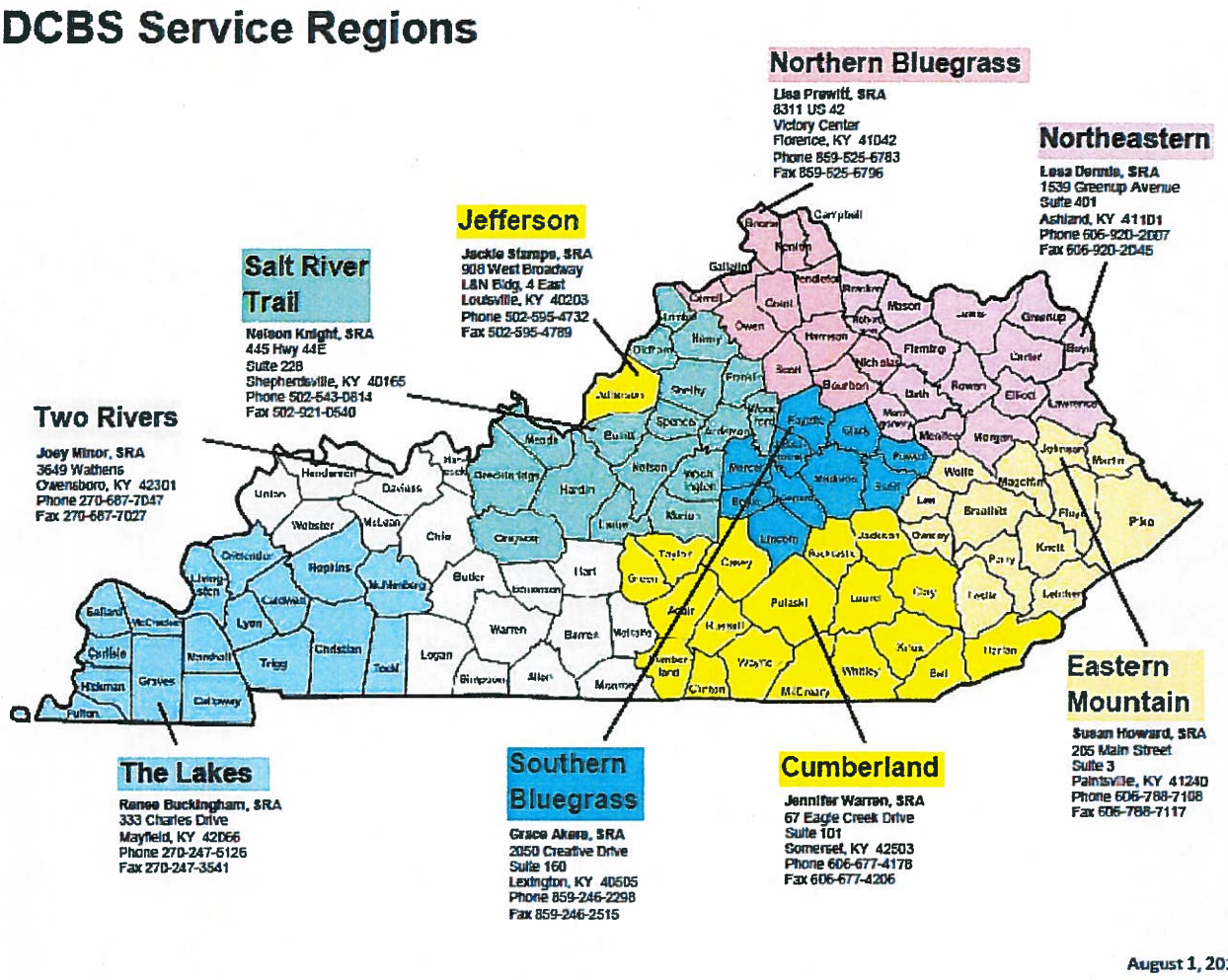
- *"Pediatric Abusive Head Trauma"* is a mandatory 1.5 hour training required by a law enacted during the 2010 General Assembly for various professionals in the child welfare, legal, and medical communities. The training was developed by Dr. Melissa Currie and presented by the DCBS Child Fatality Nurse Service Administrator for statewide implementation. This training is provided to all new employees of Protection and Permanency. There were several of these training sessions held in SFY 2014.

- *"The Effects of Parental Substance Abuse on Children"* is a training that the department provides to DCBS staff, community partners, Family Resource/Youth Service Centers staff, and the CCC Regional Networks. The goal of this training is to educate individuals on the negative effects substance abuse can have on children. It was presented at the annual Infant and Toddler Institute and the Johnson County Community of Hope Conference to a wide array of community partners during 2014.

- *"Dynamics of Domestic Violence"* is a training developed by DCBS to inform the public on the indicators and elements of homes with violence. This workshop is presented to community partners around the Commonwealth.

- *"Drug Summits: Child Welfare Decision Making"* is a training provided to frontline staff, supervisors, and management. Developed in the fall of 2011, the Drug Summits purpose was to help staff think differently about families who have the co-occurring issues of substance abuse and child maltreatment. The training addressed personal values having to do with substance abuse and provided education on addiction as a disease and disorder of the brain. Staff learned about the continuum of substance use disorders (i.e., use, abuse, dependency) and was trained on specific drugs and their effects. Drug testing was addressed during this training, and staff had the opportunity to build skills by "working" a case during the afternoon session. Areas of focus during this segment included safety and risk factors related to substance abusing families, prevention planning, case planning, relapse prevention planning, and reunification with substance abusing families. Four Drug Summit sessions were presented in October 2013 in the following service regions: The Lakes, Southern Bluegrass, Northern Bluegrass, and Jefferson.

Appendix A. Regional Map



Appendix B. Data Tables

AGE OF CHILD N=208	SFY 2014 N=28		SFY 2010-2014 TOTALS
	Fatality	Near Fatality	
Under 1 yr	2	6	75
1 year	1	3	34
2 years	2	3	26
3 years	0	1	19
4-6 years	0	2	21
7-12 years	1	1	14
13-17 years	3	3	19
Total	**9**	**19**	**208**

GENDER OF CHILD	SFY 2014 N=28		SFY 2010-2014 TOTALS
	Fatality	Near Fatality	
Male	5	15	122
Female	4	4	86
Total	**9**	**19**	**208**

RACE OF CHILD	SFY 2014 N=28		SFY 2010-2014 TOTALS
	Fatality	Near Fatality	
African American	1	2	29
Two or More Races	0	0	11
Caucasian	8	17	162
Hispanic	0	0	5
Unknown	0	0	1
Total	**9**	**19**	**208**

TYPE OF MALTX	SFY 2014 N=28		SFY 2010-2014 TOTALS
	Fatality	Near Fatality	
Physical abuse	3	8	92
Neglect	6	11	115
Physical & Neglect	0	0	1
Total	**9**	**19**	**208**

RELATIONSHIP OF PERP TO VICTIM	SFY 2014 N=28		SFY 2010-2014 TOTALS
	Fatality	Near Fatality	
Mother	3	6	53
Father	1	3	37
Both parents	2	4	34
Parent and other	0	2	38
Paramour	2	1	20
Other	1	3	22
Unknown	0	0	4
Total	**9**	**19**	**208**

CAREGIVER RISK FACTORS*	SFY 2014	SFY 2010-2014 TOTALS
Substance Abuse	18	145
Domestic violence	17	143
Mental Health	15	101

*multiple risk factors are present in most cases; therefore, these data will overlap

AMOUNT OF PRIOR HISTORY (FATALITY AND NEAR FATALITY CASES)	SFY 2014	SFY 2010-2014 TOTALS
1 prior report	7 cases	70 cases
2 prior reports	5 cases	35 cases
3-5 prior reports	6 cases	66 cases
6-9 prior reports	5 cases	27 cases
10 + reports	5 case	10 cases
Total	**28**	**208**